The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	CS/SB 2422
INTRODUCER:	Senator Storms
SUBJECT:	Medicaid
DATE:	April 2, 2009
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Bell	Wilson	HR	**Fav/CS**
2.			CF	
3.			HA	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary

Committee Substitute for SB 2422 requires the funds returned to the Agency for Health Care Administration (AHCA) from behavioral health plans that do not spend at least 80 percent of their capitation rate on behavioral health services, as required by law, to be deposited in the Medical Care Trust Fund and reallocated to the community behavioral health providers in the network of the plan making repayments to serve Medicaid recipients.

This bill substantially amends s. 409.912, F.S.

II. Present Situation:

Publicly funded substance abuse and mental health services (also known as benhavioral health services) in Florida are primarily provided or coordinated through the Department of Children and Family Services (DCF). Section 394.9082, F.S., directs the DCF and the AHCA to develop service delivery strategies to improve the coordination, integration and management of the delivery of mental health and substance abuse services. The DCF and the AHCA are authorized to contract with managing entities for the provision of behavioral health services. The managing entity concept provides an umbrella organization that subcontracts with a network of substance

abuse and/or mental health service providers in the geographic region. The managing entity is responsible for oversight of subcontractors, and the DCF's relationship is primarily with the managing entity contractor.

Florida Medicaid Program

Florida's Medicaid Program is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Florida implemented its Medicaid program on January 1, 1970, to provide medical services to indigent people. The AHCA is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

Some Medicaid services are mandatory services that must be covered by any state participating in the Medicaid program pursuant to federal law.[1] Other services, such as behavioral health services, are optional. A state may choose to include optional services in its state Medicaid plan, but if included, such services must be offered to all individuals statewide who meet Medicaid eligibility criteria as though they are mandatory benefits.[2] Similarly, some eligibility categories are mandatory[3] and some are optional.[4] Payments for services to individuals in the optional eligibility categories are subject to the availability of monies and any limitations established by the General Appropriations Act or ch. 216, F.S. For FY 2009-2010, the Florida Medicaid Program is projected to cover 2.6 million people[5] at an estimated cost of $16.3 billion.[6]

Medicaid Managed Care Programs

The state of Florida operates a Medicaid managed care program through a federal 1915(b) waiver obtained from the Centers for Medicare and Medicaid Services in 1991. The managed care waiver provides the state with the authority to mandatorily assign eligible beneficiaries[7] and, within specific areas of the state, limit choice to approved managed care providers. The federal waiver requires Florida Medicaid recipients to be given a choice of managed care providers. The Medicaid managed care program is broken into two major categories of providers: MediPass and managed care plans. However, s. 409.91211, F.S., codifies the Medicaid reform managed care pilot program in Baker, Broward, Clay, Duval, and Nassau Counties. Eligible Medicaid recipients in these counties must enroll in a managed care plan and do not have the ability to choose the MediPass program.

[1] These mandatory services are codified in s. 409.905, F.S.
[2] Optional services covered under the Florida Medicaid Program are codified in s. 409.906, F.S.
[3] s. 409.903, F.S.
[4] s. 409.904, F.S.
[5] http://edr.state.fl.us/conferences/medicaid/medcases.pdf (Last visited on March 30, 2009).
[6] http://edr.state.fl.us/conferences/medicaid/medhistory.pdf (Last visited on March 30, 2009).
[7] Certain persons are ineligible for mandatory managed care enrollment. The major population groups excluded from enrolling in managed care altogether include the Medically Needy, recipients who reside in an institution, those in family planning waivers, and those who are eligible for Medicaid through the breast and cervical cancer program. Dual eligibles (persons who have both Medicaid and Medicare coverage) are excluded from enrollment in MediPass, yet the dual eligibles and others (SOBRA pregnant women and children in foster care) may voluntarily enroll in any other type of managed care plan.

The Medicaid Provider Access System (MediPass) is a primary care case management program for Medicaid recipients developed and administered by Florida Medicaid. MediPass was established in 1991 to assure adequate access to coordinated primary care while decreasing the inappropriate utilization of medical services. In MediPass, each participating Medicaid recipient selects, or is assigned, a health care provider who furnishes primary care services, 24-hour access to care, and referral and authorization for specialty services and hospital care. The primary care providers are expected to monitor appropriateness of health care provided to their patients. MediPass providers receive a $3 monthly case management fee for each of their enrolled patients, as well as the customary reimbursement according to the Medicaid Provider Handbook for all services rendered.

The second major category of provider in the Medicaid managed care program is the managed care plan. Section 409.9122, F.S., defines managed care plans as health maintenance organizations (HMOs), exclusive provider organizations (EPOs), provider service networks (PSNs), minority physician networks, the Children's Medical Services Network, and pediatric emergency department diversion programs. These plans tend to be reimbursed through a capitated payment where the plan receives a set amount per member per month and is responsible for providing all necessary Medicaid services within that capitation rate.

Depending on where an individual lives in the state and their eligibility status, Medicaid recipients are given a choice of either MediPass or a managed care plan when they enroll in the Medicaid program. Under s. 409.9122, F.S., the AHCA is required to assign all Medicaid recipients eligible for mandatory assignment into either MediPass or a managed care plan if they do not make a choice within 30 days of eligibility. There are 23 counties with MediPass as the only managed care choice, ten counties have one managed care plan and MediPass, and 29 counties have at least two managed care plans in addition to MediPass.

As of February 2009, there were 2,329,285 individuals enrolled in the Florida Medicaid program. Of these Medicaid recipients, 210,565 were enrolled in the Medicaid reform pilot and 777,086 were enrolled in HMOs.

Medicaid Behavioral Health Services

Behavioral health services are an optional Medicaid service under s. 409.906(8), F.S. The law provides that the AHCA may pay for rehabilitative services provided to a recipient by a mental health or substance abuse provider under contract with the AHCA or the DCF. The AHCA provides reimbursement for mental health targeted case management and community behavioral health services. The DCF, Mental Health Program Office, in conjunction with the Medicaid program is responsible for approving policy for the Medicaid mental health management program.[8] The DCF is responsible for collaborating with and joint development of all behavioral health Medicaid policies, budgets, procurement documents, contracts and monitoring plans.[9] The AHCA is required to offer community mental health providers, child welfare providers, and mental health providers, under contract with the DCF under part IV of chapter 394, F.S., under

[8] See, Florida Medicaid, Mental Health Targeted Case Management Handbook. Found at: <http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_07_070601_MH_Case_Mgmt_ver2.2.pdf> (Last visited April 2, 2009).
[9] s. 409.912(4), F.S.

contract with the DCF in areas 1 and 6, and licensed pursuant to chapter 395, F.S., respectively, the opportunity to participate in any Medicaid provider network for prepaid behavioral health services.

Medicaid Prepaid Behavioral Health Plans

In March 1996, the AHCA implemented a Prepaid Mental Health Plan (PMHP) demonstration, under the authority of the 1915(b) Medicaid managed care waiver. The program was piloted for many years in two areas of the state before being expanded statewide in 2004, and is codified in s. 409.912(4), F.S. A prepaid behavioral health plan is a managed care organization that contracts with the AHCA to provide comprehensive behavioral health services to its members through a capitated payment system. The AHCA pays a per member, per month (PMPM) fee to the plan based on the age and eligibility category of each member. Services provided by these plans must include:

- Inpatient Psychiatric Hospital Services (45 days for adult recipients and 365 days for children);
- Outpatient Psychiatric Hospital Services;
- Psychiatric Physician Services;
- Community Mental Health Services; and
- Mental Health Targeted Case Management.

Medicaid recipients who elect to enroll in MediPass for the provision of their physical health care services are assigned to a prepaid behavioral health plan for the provision of their mental health services, unless they are ineligible. Ineligible persons include:

- Recipients who have both Medicaid and Medicare coverage (dual eligibles),
- Persons living in an institutional setting, such as a nursing home, state mental health treatment facility, or prison,
- Medicaid-eligible recipients receiving services through hospice,
- Recipients in the Medically Needy Program,
- Newly-enrolled recipients who have not yet chosen a health plan,
- COBRA-eligible pregnant women and presumptively eligible pregnant women,
- Individuals with private major medical coverage,
- Members of a Medicaid HMO if the HMO has chosen to provide behavioral health services,
- Recipients receiving FACT services, and
- Children enrolled in the HomeSafeNet database, unless they are enrolled in a Medicaid reform managed care plan in Broward County.

Because of their unique situation, children in the HomeSafeNet database are excluded from participating in the prepaid behavioral health plan. A separate prepaid plan was developed for these children to provide services (including behavioral health services) operated by community based lead agencies as of July 1, 2005, that are contracted through the DCF.

Prepaid behavioral health plans under s. 409.912(4)(b), F.S., are required to spend 80 percent of the capitation rate paid to the plan for the provision of behavioral health services. If a plan spends less than 80 percent of its behavioral health capitation rate on behavioral health services, then the difference must be returned to the AHCA. The AHCA is required to provide each

managed care plan that covers behavioral health services a letter that indicates the amount of capitation paid during each calendar year for behavioral health services. Medicaid HMOs that provide behavioral health services must also meet the 80 percent requirement.

Medicaid beneficiaries that choose to enroll in Medipass are automatically enrolled into prepaid behavioral health plans for behavioral health services. Beneficiaries who choose to enroll in a Medicaid HMO, receive their behavioral health services through the HMO. In Medicaid reform areas behavioral health services are provided through HMOs or PSNs.

Medicaid Managed Care Capitation

The Florida Medicaid Program uses a capitated reimbursement model for HMOs, Prepaid Behavioral Health programs, and Nursing Home Diversion programs. Managed care plan provider reimbursement requirements are specified in ss. 409.912, 409.9124, and 409.9128, F.S.

Under capitation, contracting organizations or health plans agree to provide or accept financial liability for a broad range of Medicaid covered services, in return for a fixed monthly payment for each individual enrolled in the contracting organization's plan. The Florida Medicaid Program has been using capitated reimbursement systems since the early 1990s.

The HMOs are by far the largest of these provider types and receive the majority of reimbursements within the Medicaid managed care program. Medicaid HMOs in Florida are reimbursed based on capitation payments calculated for the applicable contract year. Currently, the AHCA, as the administrating agency, is responsible for calculating the capitation payment rates for reimbursement to the HMO managed care plans.[10] The AHCA's methodology is established through the administrative rule process and is available to the public.[11] The methodology is very complex, but can be summarized as follows:

- The capitation payment is the fixed amount paid monthly by the AHCA to an HMO for each enrolled HMO member to provide covered services needed by each member during the month as specified in each contract.
- The AHCA uses 2 years of certain historical expenditure data (excluding some fees and payments as described in the rule) from the Medicaid fee-for-service program for the same service the HMO is responsible for delivering.
- These data are then categorized into "rate cells" by age, gender, eligibility group, geographic region, and are forecasted to the applicable year using inflation factors adopted by the Legislature in the Social Services Estimating Conference. Once forecasted to the applicable year, these expenditure data are adjusted to reflect policy changes adopted by the Legislature. Any policy changes that will be implemented in the coming year that may affect fee-for-service expenditures are accounted for in the capitation rates (i.e., reductions in the fee-for-service hospital inpatient reimbursement rates).
- After the adjustment for policy issues, the AHCA applies a discount factor and a trend adjustment to each rate cell to remain within appropriations. The discount factor ranges from 0 to 8 percent and varies by rate cell depending on the geographic region and eligibility category.

[10] s. 409.9124, F.S.
[11] 59G-8.100, Florida Administrative Code.

- Upon completion, the rates are reviewed and certified by an independent actuarial firm. Upon actuarial certification, and confirmation by the Centers for Medicare and Medicaid Services, the AHCA will begin reimbursing HMOs the monthly capitation payment for each recipient enrolled in the plan.

III. Effect of Proposed Changes:

The bill amends s. 409.912(4), F.S., to specify that any funds returned to the AHCA by prepaid behavioral health plans that do not utilize at least 80 percent of the capitation rate paid to the plan for the provision of behavioral health services, as required by law, must be deposited into the Medical Care Trust Fund by the AHCA. The AHCA must maintain a separate accounting of these funds. After the AHCA has returned the federal portion of Medicaid matching funds to the Federal Government, the bill directs the AHCA to allocate the remaining funds to community behavioral health providers enrolled in the network of the managed care organization that made the repayments.

The bill specifies that the funds will be allocated in proportion to each community behavioral health agency's earnings from the managed care organization making the repayment. The providers are directed to use the funds for any Medicaid allowable type of community behavioral health and case management service.

The community agencies will be reimbursed by the AHCA on a fee-for-service basis for allowable services up to their redistribution amount. The bill requires reinvestment amounts to be calculated on an annual basis, within 60 days after health plans file their annual 80-percent spending reports.

The effective date of the bill is upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill requires the funds returned to the AHCA from the Medicaid managed care plans that provide behavioral health services that do not spend 80 percent of their behavioral health capitation on behavioral health services to be reinvested in community behavioral health care. In 2007, Medicaid managed care plans returned $15 million under this program. Approximately 50 percent of the funds were returned to the federal government. The redistribution of funds in the bill may negatively impact Medicaid programs or services that had previously received the funds.

The bill would increase the amount of state funds supporting behavioral health care in Florida.

VI. Technical Deficiencies:

None.

VII. Related Issues:

There is some inconsistency in the terminology used in the bill.

- On lines 266 and 268 the bill references "managed care organizations." Managed care organizations are not defined in the law governing the Medicaid program or commonly used terminology in the administration of the Medicaid program. The term "managed care plan," as defined in s. 409.901(13), F.S., or referencing any entity providing services under s. 409.912(4)(b), F.S., would provide more clarity.
- Lines 267 and 271 reference a "community health agency" and "community agencies," respectively. It is unclear if these are the same organizations. It is unclear if the bill is referencing behavioral health managing entities under s. 394, 9082, F.S., or other community health entities.
- The use of the term "health plans" on line 275 is inconsistent with the rest of the bill language.

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Regulation on April 1, 2009:
The committee substitute substantially changed the bill in the following ways:

- Removes the requirement to risk-adjust rates for all capitated Medicaid managed care plans;
- Removes the requirement for the AHCA to contract with prepaid behavioral health plans as long as the AHCA operates the Medipass sytem;
- Specifies that the funds returned by managed care plans providing behavioral health services to Medicaid beneficiaries will be redistributed by the AHCA to community health agencies.

B. Amendments:

None.